imprimis Rx

Fax

To: Park Compounding

Fax: 949-551-1950 **Phone:** 858-704-4644

From: _____

Fax: _____

Phone: _____

Number of Pages: _____ Date: _____

Comments: _____

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☒ PROTECTED HEALTH INFORMATION

☐ BUSINESS CONFIDENTIAL INFORMATION

This fax is intended only for the exclusive use of the addressee(s), and may contain privileged or confidential information. If you are not the intended recepient, or the person responsible for delivering the fax to the intended recepient, be advised you have received this fax in error and that use, dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this fax in error, please destroy the attached document(s) and immediately notify the sender of the error.

Please deliver to: Order Fulfillment with this cover sheet to protect its contents.

imprimis Rx

PARK COMPOUNDING
Irvine, California
An Imprimis*Rx *Pharmacy

Ophthalmic Order Form - TOPICAL

Phone: **858-704-4644**

Order Date: ____/____/_____ **Earliest Date To Be Administered:** ____/____/_____

Please allow for 72-hours turnaround time (3 business days) before order will ship. Incomplete order submissions may delay processing.

Physician Information

Required

Prescribing Physician: _____

DEA: _____ NPI#: _____

Center/Clinic: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Primary Contact: _____

Email: _____

Center/Clinic May Receive Shipments on Fridays: ◯ YES ◯ NO

***If multiple prescribing physicians, use separate order form for each.**

Patient Information

Required

Patient Name: _____

Birthdate: ____/____/_____ Phone: (_____) _____ - _____

Address: _____

_____

Known Drug Allergies: _____

_____

☐ No Known Drug Allergies (NKDA)

Patient Profile(s) or Block Schedule Attached: ◯ YES ◯ NO

# of Patients*: _____

Paid by: ☐ Physician/Clinic ☐ Patient

Ship to: ☐ Physician/Clinic ☐ Patient

Medication Orders

If you need a medication not listed, please contact us at **858-704-4644**

Medication	Strength or Concentration	Size/Volume	Instructions for use	Quantity	# Refills
☐ **Pred-Moxi** (Prednisolone acetate and moxifloxacin hydrochloride)	**(1/0.5)%**** *alternate*_____	☐ **3mL or 6mL dropper** ☐	**Instill into the affected eye(s) following the instructions provided by your prescriber**		
☐ **Pred-Ketor** (Prednisolone acetate and ketorolac tromethamine)	**(1/0.4)%**** *alternate*_____	☐ **3mL or 6mL dropper** ☐	**Instill into the affected eye(s) following the instructions provided by your prescriber**		
☐ **Pred-Moxi-Ketor** (Prednisolone acetate, moxifloxacin hydrochloride and ketorolac tromethamine)	**(1/0.5/0.4)%**** *alternate*_____	☐ **3mL or 6mL dropper** ☐	**Instill into the affected eye(s) following the instructions provided by your prescriber**		
☐	*alternate*_____				

*Prescribers are reminded that state law allows patients to receive medications from a pharmacy of their choice
**Representative formulation. Customizable within certain ranges. Please contact the pharmacist to discuss.

❗ REMINDER: Please check patient information has been included for all medications before submitting

Order Submission

THIS FORM CONSTITUTES A PHYSICIAN'S ORDER/PRESCRIPTION WHEN SIGNED BY THE PHYSICIAN

Please FAX with cover sheet to Park Compounding

949-551-1950

Authorized Physician's Signature

X _____

Please allow for 72-hours turnaround time (3 business days) before order will ship. Incomplete order submissions may delay processing.

# of Prescriptions _____

Payment Information

IF NO CREDIT CARD ON FILE AND YOU ARE NOT CURRENTLY BEING INVOICED, PLEASE SUBMIT THE FOLLOWING:

Credit Card Number: _____ Expiration: ____/____ CVC Code: _____ Billing Zip: _____

This form is provided in an effort to improve patient safety.

Patient Information

First & Last Name	Birthdate	Address	Phone Number	Known Drug Allergies
				NKDA ☐
☐ Ship to Patient ☐ Ship to Clinic	Rx Start Date:	Number of Refills:		Paid by: ☐ Physician/Clinic ☐ Patient
Credit Card Number: ______________	Expiration: ____/____	CVC Code: ______	Billing Zip: ______	

First & Last Name	Birthdate	Address	Phone Number	Known Drug Allergies
				NKDA ☐
☐ Ship to Patient ☐ Ship to Clinic	Rx Start Date:	Number of Refills:		Paid by: ☐ Physician/Clinic ☐ Patient
Credit Card Number: ______________	Expiration: ____/____	CVC Code: ______	Billing Zip: ______	

First & Last Name	Birthdate	Address	Phone Number	Known Drug Allergies
				NKDA ☐
☐ Ship to Patient ☐ Ship to Clinic	Rx Start Date:	Number of Refills:		Paid by: ☐ Physician/Clinic ☐ Patient
Credit Card Number: ______________	Expiration: ____/____	CVC Code: ______	Billing Zip: ______	

First & Last Name	Birthdate	Address	Phone Number	Known Drug Allergies
				NKDA ☐
☐ Ship to Patient ☐ Ship to Clinic	Rx Start Date:	Number of Refills:		Paid by: ☐ Physician/Clinic ☐ Patient
Credit Card Number: ______________	Expiration: ____/____	CVC Code: ______	Billing Zip: ______	

First & Last Name	Birthdate	Address	Phone Number	Known Drug Allergies
				NKDA ☐
☐ Ship to Patient ☐ Ship to Clinic	Rx Start Date:	Number of Refills:		Paid by: ☐ Physician/Clinic ☐ Patient
Credit Card Number: ______________	Expiration: ____/____	CVC Code: ______	Billing Zip: ______	

First & Last Name	Birthdate	Address	Phone Number	Known Drug Allergies
				NKDA ☐
☐ Ship to Patient ☐ Ship to Clinic	Rx Start Date:	Number of Refills:		Paid by: ☐ Physician/Clinic ☐ Patient
Credit Card Number: ______________	Expiration: ____/____	CVC Code: ______	Billing Zip: ______	

When shipping multiple patients' prescriptions together to a physician or clinic, please indicate *"Earliest Date to be Administered"* on order form Page 1 to determine ship date.
When shipping individual prescriptions directly to patients, indicate *"Rx Start Date"* for each on Page 2.

<u>The pharmacy will plan for all orders to arrive by on day prior to these dates.</u>